DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
2300 E STREET NW
WASHINGTON DC 20372-5300

6320
Ser 32RM/0230
11 Jun 99

IN REPLY REFER TO

From: Chief, Bureau of Medicine and Surgery

Subj: CLARIFICATION OF JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) SENTINEL EVENT REPORTING POLICY

Ref: (a) DoD 6025.13

Encl: (1) Sample Appointment Memo For A Quality Assurance Inquiry
(2) Confidentiality Statements for Sentinel Event Related Documents

1. The purpose of this letter is to clarify the Bureau of Medicine and Surgery (BUMED) policy on sentinel event reporting.

2. Existing Assistant Secretary of Defense (Health Affairs) policy (reference (a)) indicates "DoD facilities are required to comply with the JCAHO sentinel events reporting process." In November 1998, JCAHO changed its requirements for sentinel event reporting from a mandatory to a voluntary process. This change in JCAHO policy has caused confusion for military treatment facilities (MTFs) with regard to their reporting obligations.

3. Participation in the sentinel event reporting program provides Navy Medicine with many advantages including:

a. Contributing to a national "lessons learned " database; obtaining assistance from JCAHO with preparation of root cause analyses; and,

b. reassuring the public and our constituents that we take these events seriously and make a concerted effort to implement systems to prevent or minimize similar occurrences.

4. All Navy MTFs will process all sentinel events as follows:

a. Notify JCAHO (by fax or phone)and BUMED Risk Management (by phone) of the sentinel event within five working days of the adverse event or of becoming aware of the event;

b. identify the review process documents, including each page of the root cause analysis form, as a Quality Assurance activity protected under 10 U.S.C. § 1102 using the language noted in enclosures (1) and(2); and;

c. submit the original completed root cause analysis and action plan to JCAHO within 45 days after reporting the event and send a copy to BUMED (MED-32RM).

Subj: CLARIFICATION OF JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS (JCAHO) SENTINEL EVENT REPORTING POLICY

5. If you have any questions regarding the implementation of this policy, please contact me or Carmen Birk (BUMED Risk Manager) at (202) 762-3081.

D. C. ARTHUR
Assistant Chief for Health
Care Operations

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# SAMPLE APPOINTMENT MEMO FOR A QUALITY ASSURANCE INQUIRY

MEMORANDUM

From:
To:

Subj: APPOINTMENT AS SENIOR INVESTIGATOR FOR A QUALITY ASSURANCE INQUIRY

Encl: (1) Framework for A Root Cause Analysis

1. You are hereby appointed senior investigator for a Quality Assurance inquiry into the care provided to XX (name) on XX (date). You will be assisted by:

XX (name)
XX (name)

2. Preliminary information indicates that the patient XX (name) had the following experience XX (describe event). From the information available at this time, this event meets the criteria for a sentinel event.

3. Therefore, special timelines are appropriate and the use of enclosure (1) for performing a root cause analysis and reporting your results is required. Your final report is due in the XX (name) office on XX (date). The Office of XX (name) will contact you on XX (date) for a status report, if the report has not already been provided. Your report will be distributed to the responsible director(s) and will be placed on the Executive Committee of the Medical Staff agenda for the XX (date) meeting.

4. We ask that your analysis include the use of appropriate quality tools, such as a flow diagram. This tool can be used to clarify the current process, develop a modified process or convey to all concerned the proper procedures to be followed in the future.

5. Please note that documents and records created pursuant to this order are Quality Assurance materials, which are confidential and privileged under 10 U.S.C. § 1102.

6. If you have any questions during your review, please contact XX (name) in the XX (name) office at XX (phone number).

Enclosure (1)

CONFIDENTIALITY STATEMENTS FOR SENTINEL EVENT RELATED DOCUMENTS

1. Include the following statements on Sentinel Event related documents including appointment letters, letters to JCAHO and the Root Cause Analysis document.

a. Place the following statement on the bottom of each page of the Root Cause Analysis report form:

> Do not release. ***Confidential and privileged Quality Assurance material under 10 U.S.C. § 1102.***

b. Place the following statement in the body of the appointment letter authorizing the investigation.

> ***Documents and records created pursuant to this order are Quality Assurance materials, which are confidential and privileged under 10 U.S.C. § 1102.***

c. Place the following statement in the body of the letter forwarding a completed Root Cause Analysis to JCAHO:

> ***This Root Cause Analysis was produced as a part of this facility's Quality Assurance program, and is strictly confidential and privileged. No part may be disclosed, subject to discovery or admitted into evidence in any judicial or administrative proceeding, except in accordance with 10 U.S.C. § 1102.***

2. If you have any questions regarding the contents of this enclosure, please contact Carmen Birk, BUMED, Risk Manager, at (202) 762-3081 or DSN 762-3081.

# Minimum Scope of Root Cause Analysis for Specific Types of Sentinel Events

Detailed inquiry into these areas is expected when conducting a root cause analysis for the specified type of sentinel event. Inquiry into areas not checked (or not listed) should be conducted as appropriate for the specific event under review.

| | Suicide (24 hr care) | Medication error | Procedure complication | Wrong site surgery | Delay in treatment | Death in restraints | Elopement death | Assault/rape /homicide | Transfusion death | Infant abduction or wrong dischg. |
|---|---|---|---|---|---|---|---|---|---|---|
| Behavioral assessment process * | X | | | | | X | X | X | | |
| Physical assessment process ** | X | | | X | | X | X | | | |
| Patient identification process | | X | | X | | | | | X | |
| Patient observation procedures | X | | | | | X | X | X | | |
| Care planning process | X | | | | | X | X | | | |
| Staffing levels | X | X | X | X | X | X | X | X | X | X |
| Orientation & training of staff | X | X | X | | X | | X | X | X | X |
| Competency assessment/credentialing | X | X | X | | X | | X | X | | X |
| Supervision of staff *** | | X | X | | X | | | | X | |
| Communication with patient/family | | | | X | X | X | | | | |
| Communication among staff members | | X | X | X | X | X | | | X | X |
| Availability of information | | X | X | X | X | | | | X | |
| Adequacy of technological support | | X | X | | | | | | | |
| Equipment maintenance/management | | | X | | | X | | | | |
| Physical environment **** | X | X | X | | | | X | X | X | X |
| Security systems and processes | X | | | | | | X | X | | X |
| Control of medications: storage/access | | X | | | | | | | | |
| Labeling of medications | | X | | | | | | | | |

* Includes the process for assessing risk to self (and to others, in the case of assault, rape, or homicide where a patient is the assailant).
** Includes search for contraband.
*** Includes supervision of physicians-in-training.
**** Includes furnishings; hardware (e.g., bars, hooks, rods); lighting; distractions.